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## HCBS SERVICE PLAN

Member Name:		Enrollment Date:		Discharge	Readmits
		Update:			
Level of Care Evaluation Date:		Met LOC: YES <input type="checkbox"/> NO <input type="checkbox"/>		Screened by: MPQH <input type="checkbox"/> CMT <input type="checkbox"/>	
Social Security Number:	Medicaid ID#:	Phone Number:			
Physical Address:		Mailing address:			
Care Category <input type="checkbox"/> Basic <input type="checkbox"/> AR <input type="checkbox"/> CC3		Email Address:			
Date of Birth:	Height:	Weight:	Sex:	Marital Status:	
Legal Representative: <input type="checkbox"/> POA Type: _____ <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Payee <input type="checkbox"/> Other: _____ —					
Name		Address:		Phone:	
Significant Other Name(relationship):		Address:		Phone:	
Primary Health Care Provider:		Address:		Phone:	
Additional Health Care Providers & Type:		Address:		Phone:	
Additional Health Care Providers & Type:		Address:		Phone:	
OPA:					
Pharmacy:				Phone:	
Residential Status: <input type="checkbox"/> Lives Alone <input type="checkbox"/> Lives with family/significant other <input type="checkbox"/> Live in attendant		<input type="checkbox"/> Residential Habilitation; Type: _____ <input type="checkbox"/> Other:			
Medicare <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicare #		Effective Date (if Known):	
Medicare D:		Other Insurance:		Veteran or spouse of Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No	
Primary Diagnosis:				ICD 10:	

## ADVANCE DIRECTIVES

Living Will/Advance Directives ☐ Yes ☐ No ☐ POLST ☐ MT end of life Registry ☐ Other \_\_\_\_\_

Where are your Advance Directives kept:

Name of your Health Care Proxy  
If Other than Legal Rep or POA:

Burial Plan: ☐ Yes ☐ No Explain:

Page 2 Name:

Date:

<b>MEDICAL INFORMATION</b>							
<b>NUTRITIONAL STATUS</b>							
Diet:	<input type="checkbox"/> General <input type="checkbox"/> Diabetic <input type="checkbox"/> Low salt <input type="checkbox"/> Other (Specify):						
Supplements							
<b>MEDICAL DIAGNOSIS</b>							
Date	Medical Diagnoses	ICD-9/10 Code	Date	Medical Diagnoses	ICD-10 Code		
<b>MEDICATION LIST</b>							
Date	Medications	Dosage	Frequency	Date	Medications	Dosage	Frequency
Medication Allergies:				Other Allergies:			
Medication Dispensing System:				Pharmacy:			
Comments:							
<b>PSYCHOSOCIAL INDICATORS</b>							
List indicators that currently affect member and/or service delivery:							
Mental status/orientation :							

Page 3 Name:

Date:

## FUNCTIONAL OVERVIEW

Task	Independent	Needs Assistance	Dependent	Task	Independent	Needs Assistance	Dependent
Bathing				Laundry			
Dressing				Shopping			
Exercise				Socialization			
Grooming				Telephone			
Toileting				Vision			
Continence				Hearing			
Transfer				Speech			
Mobility				Banking			
Assistive Devices				Money Mgmt			
Meal Preparation				Orientation			
Eating				Transportation			
Medications				Time Mgmt			
Escort				Other			
Household				Other			

## ASSISTIVE DEVICE INFORMATION

Needs	Has	Device	Needs	Has	Device
		Bath Chair/Bench			Environmental Control Unit
		Cane			Non-Skid tub mat
		Commode Chair			Communication Device
		Commode seat, raised rails			Scooter
		Grab Bars			Personal Alert/Safety/Response System
		Handheld shower			Trapeze Bar
		Specialized Bed			Walker
		Positioning Bar			Wheelchair
		Lift System/Lift Chair			Wheelchair Ramp
		Service Animals			Other:

DME Provider(s):

[illegible]

## PLAN ASSESSMENT SUMMARY

Physical Summary:

Long-Term Goals:

Short-Term Objectives:

Psychosocial Summary:

Long-Term Goals:

Short-Term Objectives:

Discharge Plan:

Emergency Backup Plan:

Emergency Evacuation Plan:

Emergency Contact:

Phone:

Location of Medications & Important Documents:

### SAFETY INFORMATION

Please check the following safety concerns as they apply:

<input type="checkbox"/>	Access to phone in emergency is limited	<input type="checkbox"/>	Entrance/exit to home not accessible	<input type="checkbox"/>	Concern for safety in community
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Comments/Issues:

Need for formal risk assessment Yes ☐ No ☐ Date assessment will be completed:

## SIGNATURE SECTION

My plan addresses my needs and personal goals, including health and safety.	<input type="checkbox"/>
I have made a free choice of services and qualified providers for each service included in my Service Plan.	<input type="checkbox"/>
I have received a choice between institutional care or HCBS.	<input type="checkbox"/>
I have received information on Abuse/Neglect and Exploitation and know how to report.	<input type="checkbox"/>
I understand there is a service plan cost limit and a limit on the type of services available through the HCBS Program.	<input type="checkbox"/>
I have participated in the development of this service plan and agree with it.	<input type="checkbox"/>
The case management team has verified that HCBS services in this plan cannot be reimbursed by state plan Medicaid, Medicare or private insurance.	<input type="checkbox"/>
Member Signature:	Date:
Legal Representative:	Date:
Primary Care Provider Signature:	Date:
CMT Nurse:	Date:
CMT: Social Worker:	Date:
Other:	Date:

## ANY OTHER COMMENTS / NOTES

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